BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Kamalakar Rambhatla, M.D. Physician's and Surgeon's Certificate No. A 32691 Respondent	Case No. 800-2017-032890

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 16, 2021.

IT IS SO ORDERED June 16, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation against:

KAMALAKAR RAMBHATLA, M.D.

Physician's and Surgeon's Certificate A 32691

Respondent.

Agency Case No. 800-2017-032890

OAH No. 2020040761

PROPOSED DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference and telephone on April 19, April 20, and April 21, 2021.

Rebecca L. Smith, Deputy Attorney General, represented William Prasifka (Complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Peter R. Osinoff and Carolyn Lindholm, Attorneys at Law with Bonne, Bridges, Mueller, O'Keefe & Nichols, represented Kamalakar Rambhatla, M.D. (Respondent), who appeared by videoconference.

During the hearing, the ALJ granted Complainant's motion to seal several exhibits to protect privacy rights and signed a separate written order placing the exhibits under seal. In addition, Complainant amended the Accusation (Exhibit 1) by replacing the reference to "Christine J. Lally" with "William Prasifka" in paragraph 1, line 1, and the word "her" with "his" in paragraph 49, line 14.

Testimony and documentary evidence were received. The record was closed and the matter was submitted for decision on April 21, 2021.

SUMMARY

Complainant requests the Board take disciplinary action against Respondent's physician's and surgeon's certificate for alleged gross negligence, repeated negligent acts, and failure to maintain accurate records in connection with the care and treatment of two patients. Respondent denies the allegations and asserts the evidence does not support disciplinary action. Complainant failed to prove by clear and convincing evidence Respondent committed gross negligence or repeated acts of negligence. However, Complainant established Respondent failed to maintain adequate and accurate records for one patient. Considering the limited scope of Respondent's recordkeeping violation and the strong mitigation and rehabilitation evidence offered by Respondent, a public reprimand is the appropriate level of discipline.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 31, 1978, the Board issued Physician's and Surgeon's Certificate Number A 32691 (certificate) to Respondent. The certificate is scheduled to expire on May 31, 2022. (Ex. 2.)

2. Christine J. Lally filed the Accusation, dated March 25, 2020, while acting in her official capacity as the Interim Executive Director of the Board. On April 9, 2020, Respondent filed a Notice of Defense. This hearing followed.

The Accusation

3. The events at issue in the Accusation concern two patients, Patient 1[1] and Patient 2, both of whom were treated at Greater El Monte Community Hospital (GEMCH), where Respondent served as the sole consulting pulmonologist during the relevant period. A doctor with privileges at GEMCH complained of Respondent's care of the two patients to the Board; no complaints were made by the patients or their families. The complaining doctor did not testify at the hearing.

4. After a Board investigation into the complaining doctor's claims, Complainant charged Respondent with gross negligence in allegedly failing to manage Patient 1's pleural effusion; repeated negligence for (a) failing to manage Patient 1's pleural effusion; (b) failing to recognize the alleged deterioration of Patient 1's medical condition during the periods his nurse practitioner Desirae Mutuc (NP Mutuc)

[1] The two patients are identified by numbers to preserve confidentiality.

provided care and treatment to Patient 1; and (c) failing to recognize and address Patient 2's abnormal laboratory value on the day of her discharge from GEMCH; as well as unprofessional conduct for allegedly failing to maintain adequate and accurate medical records relating to Patient 1's care and treatment.

Expert Testimony

5. Complainant offered the testimony and reports of Deepak Shrivastava, M.D., to establish the standard of care for the treatment of Patients 1 and 2. (Exs. 5, 10.) Dr. Shrivastava is board-certified in internal medicine, pulmonary medicine, critical care medicine, and sleep medicine, and received board re-certification in pulmonary medicine, critical care medicine, and sleep medicine. He is also board eligible in hospice medicine. Dr. Shrivastava has received multiple awards and honors. He has been a consultant and an expert reviewer for the Board since 2006. He currently serves as Clinical Professor for VCF Internal Medicine, Pulmonary/Critical Care Medicine, and Sleep Medicine at the UC Davis School of Medicine and on the pulmonary, critical care, and sleep medicine faculty at San Joaquin General Hospital. Dr. Shrivastava also serves as the Associate Medical Director of Health Plan of San Joaquin, a managed care organization, the medical director of various hospice organizations, medical director and staff physician at several sleep centers, and the associate medical director of the PACE program. (Ex. 4.)

6. Respondent offered the testimony and report of Lawrence R. Brooks, M.D., to establish the standard of care for the treatment of Patients 1 and 2. (Ex. E.) Dr. Brooks is board-certified in internal medicine, pulmonary medicine, and critical care medicine, and has recertified twice in the latter two specialties. In 1989, Dr. Brooks joined California Lung Associates, a private practice group specializing in pulmonology. He was instrumental in the developing hospitalist movement and was a

founder of Cogent Healthcare (now part of Sound Physicians), a national company providing hospitalist and intensivist programs. He served as a hospitalist physician mentor teaching the art and science of hospitalist medicine to physicians across the country. Dr. Brooks also served nine years in organized medical staff governance at Good Samaritan Hospital in Los Angeles, including three years as chief of the medical staff. He has chaired multiple committees overseeing quality assurance, credentials, peer review, and bylaws and won several awards. In 2012, Dr. Brooks left California Lung Associates and became a full-time Intensivist for Sound Critical Care. His present position is Medical Director of the Intensive Care Unit (ICU) and Program Medical Director of the Intensivist and Nocturnist Services at Adventist Health White Memorial in Los Angeles. In addition to providing critical care services to patients, Dr. Brooks is responsible for all quality assurance in the ICU and the critical care training of residents. He also serves as the Chairman of the ICU Practice Guidelines Committee and the Code Blue Committee and is a member of several other hospital committees. (Ex. D.)

7. Drs. Shrivastava and Brooks were both qualified to testify as experts regarding the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimony and bases for their opinions, as set forth more fully below.

Factual Background

8. Respondent is 69 years old. He earned his medical degree in 1973 from Osmania Medical College in Hyderabad, India. He was a post-doctorate research fellow in infectious diseases at Charles Drew Medical School in Los Angeles and completed his internship and residency in internal medicine at Martin Luther King Jr. General Hospital in Los Angeles. Post-residency, Respondent was a fellow in pulmonary disease

in the UCLA-Veteran's Administration program and a senior fellow in pulmonary disease at City of Hope Medical Center in Duarte. Since 1983, Respondent has been in private practice specializing in pulmonary medicine, critical care medicine, and sleep medicine. Respondent became board-certified in internal medicine and pulmonary medicine in 1984; his board-certification in pulmonary medicine lapsed in 2008, and he has not sought recertification. (Ex. C.)

9. Respondent is currently on staff at Arcadia Methodist Hospital, GEMCH, Beverly Hospital, Garfield Medical Center, and Alhambra Hospital Medical Center as well as three long-term acute care hospitals, Kindred Hospital in Baldwin Park, Kindred Hospital in West Covina, and Monrovia Memorial Hospital. He has been on the Beverly Hospital staff for 30 years and the GEMCH staff for 20 years. (Ex. C.)

10. Respondent was the consulting pulmonologist for Patient 1 and the assigned attending physician for Patient 2. Respondent employed NP Mutuc to assist him with the care of Patient 1 and Patient 2. NP Mutuc was Respondent's first nurse practitioner, and Respondent was responsible for her training.

11. NP Mutuc testified in response to a subpoena issued by Complainant. Her testimony was credible and candid. NP Mutuc is currently employed as a nurse practitioner at Chino Valley Hospital. She received a doctorate and master's in nursing and attended medical school until she was forced to leave for financial reasons. NP Mutuc worked for Respondent from 2016 to 2018, when she left to spend more time with her family and attend school.

12. It was NP Mutuc's custom and practice to meet with Respondent each morning to review and discuss the care of Respondent's patients. NP Mutuc would arrive at the hospital before Respondent and collect the available paperwork relating

to Respondent's patients. She would then meet with Respondent, discuss each of Respondent's patients, and together, they would review patient reports from treatment providers, laboratory results, and x-rays. Afterward, she and Respondent would see patients together, unless she or Respondent was unavailable. NP Mutuc was responsible for dictating the notes of their patient visits, and Respondent was responsible for reviewing the notes and co-signing them. The timing of his signatures did not always coincide with those of NP Mutuc, and Respondent at times amended the notes to add his own thoughts.

TREATMENT OF PATIENT 1

First Admission

13. Patient 1 was a 98-year-old woman. She was first admitted to GEMCH on November 25, 2016, with complaints of a "cough, sore throat, chest wall pain, body aches, fever." (Ex. 6., p. 12, A72.[2]) . At the time of admission, Patient 1 had a history of diabetes, hypertension, and transient ischemic attacks (TIA's). (*Id.* at p. 13, A73.)

14. A chest x-ray taken on the day of Patient 1's admission found her lungs to be clear. The radiologist noted the presence of calcified atherosclerotic disease but no clinically significant pneumothorax or pleural effusion. (Ex. 6, p. 84, A144.) The radiologist's impression identified stable cardiomegaly (enlarged heart) and calcified atherosclerotic disease (narrowing or hardening of the arteries.) (*Ibid.*)

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[2] Page references beginning with "A" or "B" are to the CaseLines page numbers. CaseLines is a digital evidence software program used for document management during the hearing.

15. Mohan P. Rao, M.D., a nephrologist, was assigned as Patient 1's admitting doctor. He diagnosed Patient 1 with dehydration, azotemia, hyponatremia, and acute bronchitis. (Ex. 6, p. 394, A454.) Dr. Rao's initial plan was to hydrate Patient 1 cautiously and treat her with broad-spectrum intravenous (IV) antibiotics and a bronchodilator. (*Id.* at p. 395, A455). His note reflects that Patient 1's family requested "DNR," meaning "do not resuscitate." (*Ibid.*) Hospital records indicate Patient No. 1 agreed to a Level II Selective Therapeutic Effort, which allowed the use of chest compressions, vasopressors/inotropics, and anti-arrhythmics, but disallowed intubation or defibrillation, as life-saving measures. (*Id.* at p. 67, A127.)

16. A follow-up chest x-ray taken on November 29, 2016, showed "mild hazy opacities" at Patient 1's bilateral lung bases, with the left greater than the right, compatible with small pleural effusions with adjacent "atelectasis/consolidation." (Ex. 6, p. 86, A146.) The radiologist did not observe any pneumothorax. The x-ray impression note states, "Please correlate clinically if concern for underlying congestive heart failure versus infectious/inflammatory process." The radiologist also observed atherosclerotic vascular disease. (*Ibid.*)

17. Following the November 29 x-ray, Dr. Rao ordered infectious disease, cardiology, and pulmonology consults for Patient 1. Respondent performed his pulmonary consultation on November 30, 2016, with the assistance of NP Mutuc. (Ex. 6, pp. 100–102, A160–A162.) According to that visit's note, Patient 1 acknowledged a cough but denied any shortness of breath. The examination found bilateral wheezes upon auscultation. The note includes the radiologist's findings of bilateral pleural effusions. The note's "assessment" was acute bronchitis, fever, diabetes, hypertension, and history of TIA, although Patient 1 was afebrile at the time. (*Id.* at p. 101, A161.) The "Plan" section of the note stated, "Will continue patient on IV Solu-Medrol, Mucomyst,

bronchodilators. Will do a repeat chest x-ray. Continue patient on IV antibiotics and antitussives, and will continue to monitor the patient for any respiratory distress and fever." (*Ibid.*) The note indicated NP Mutuc discussed the plan of care with Respondent. (*Ibid.*)

18. A November 30 echocardiogram of Patient 1 showed normal left ventricle size and systolic function, mild concentric left ventricular hypotrophy, diastolic dysfunction of Patient 1's left ventricle, borderline aortic stenosis, calcified mitral valve, and severe pulmonary hypertension. (Ex. 6, p. 117, A177.)

19. Soon Y. Kwun, M.D., consulted as Patient 1's cardiologist. In his examination of December 1, 2016, Dr. Kwun noted Patient 1 complained of a productive cough but denied chest pain or shortness of breath. (Ex. 6, p. 109, A169.) His note reflected his puzzlement as to the cause of Patient 1's pleural effusions. He wrote that Patient 1 had no symptoms of orthopnea (breathlessness in the recumbent position) or shortness of breath. Dr. Kwun doubted Patient 1's aortic stenosis was significant enough to cause acute congestive heart failure. His note did not address Patient 1's diastolic dysfunction. Dr. Kwun also observed that Patient 1's metabolic panel showed a further increase of BUN "suggesting prerenal azotemia," which is "not an uncommon presentation for acute CHF [congestive heart failure] with bilateral pleural effusion." (*Ibid.*) Dr. Kwun ordered the discontinuance of IV Lasix (a diuretic) and advised a CT chest scan. He also stated that Patient 1 "might need a thoracentesis." (*Id.* at p. 110, A170.)

20. On December 1, 2016, a CAT scan was taken of Patient 1's chest. The CAT scan showed moderate bilateral pleural effusions with severe consolidation at both lung bases versus atelectasis [partial collapse of the lung]. (Ex. 6, p. 90, A150.) The CAT scan found severe calcified plaque in the coronary arteries. The radiologist's

impressions were "severe bibasilar atelectasis versus bibasilar pneumonia," which the radiologist requested to "[p]lease correlate clinically." (*Ibid.*) The radiologist also found "severe atherosclerotic disease in the coronary arteries." (*Id.* at p. 91, A151.)

21. In his note of December 2, 2016, Dr. Kwun observed Patient 1 to be alert and oriented, comfortable, and without any distress. Her lung sounds revealed no wheezing or rales. (Ex. 6, p. 111, A171.) According to his note, Dr. Kwun believed that acute congestive heart failure was "less likely the cause for pleural effusion" based on Patient 1's clinical presentation and the normal ejection fraction of the left ventricle. Dr. Kwun again did not address the likelihood of diastolic dysfunction as a cause of the effusion. Dr. Kwun observed that Patient 1 continued to suffer from bronchitis. (*Ibid.*) Finally, Dr. Kwun noted that if Patient 1 continues to have pleural effusion, she "might need a thoracentesis." (*Id.* at p. 112, A172.) He repeated his opinion of Patient 1's potential need for a thoracentesis in his note regarding his December 3 examination. (*Id.* at p. 113, A173.) He also indicated that Patient 1 may need to be transferred to the ICU if her arterial blood gas (ABG) test results were significantly abnormal. (*Ibid.*)

22. According to the progress notes for those visits, Respondent's December 1, December 2, and December 3, 2016 examinations of Patient 1 found her to be afebrile, alert, with no shortness of breath or respiratory distress. Respondent's treatment plan in each day's note remains unchanged, i.e., to treat Patient 1 with IV antibiotics, bronchodilators, and supplemental oxygen. (Ex. 6, pp. 410–411, 418–419 422–423, A470-A471, A478-A479; A482–A483.) None of the notes refer to Patient 1's CT scan or electrocardiogram or mention the possibility of performing a thoracentesis.

23. There were no marked changes in Patient 1's chest x-rays from November 30, 2016, through December 4, 2016, although the radiologist observed a "slightly increased CHF" on December 1. (Ex. 6, pp. 88, 89, 92–94, A148, A149, A152–

A154.) The x-rays continued to show small bilateral pleural effusions with the left side greater than the right. (*Ibid.*)

24. Respondent examined Patient 1 on December 4, 2016, without NP Mutuc's assistance. In his note, Respondent reported his examination of Patient 1's lungs revealed bilateral wheezes with decreased breath sounds in the bases. Respondent indicated he spent a "significant time" with Patient 1's family explaining Patient 1's treatment and workup since her admission, including the "venous Doppler studies[,] CT scan of the chest[,] echocardiogram results as well as current antibiotics and inhalation treatments." (Ex. 6, p. 426, A486.) Respondent's note also reflects he discussed Patient 1's blood gasses with the family and also spoke with Dr. Kwun. The note acknowledged Dr. Kwun's belief that Patient 1's bilateral pleural effusions and atelectasis were not caused by significant congestive heart failure. (*Ibid.*) Respondent added IV steroids, increasing the insulin sliding scale to a high dose, and the use of BiPAP on an as-needed basis to his treatment plan. Respondent also noted he would consider a thoracentesis if Patient 1's distress and cough persisted. (*Id.* at p. 428, A488.) Dr. Kwun's note of the same day confirmed he discussed Patient 1's condition with Respondent and agreed with Respondent's decision to treat Patient 1 with additional steroids and not transfer her to the ICU. (*Id.* at p. 115, A175.)

25. Respondent's examinations of Patient 1 performed on December 5 and December 6 did not find Patient 1 in any respiratory distress. (Ex. 6, pp. 431–433, 436–438, A491–493, A496–498.) The December 5 note indicates that Patient 1's December 5 x-ray showed increased effusions from the day earlier. (*Id.* at p. 432, A492.) Nevertheless, Respondent did not change his treatment plan from December 4. (*Ibid.*) The notes do not mention performing a thoracentesis.

26. Dr. Kwun's December 5 and 6, 2016 examination notes reflected Patient 1 was more alert and oriented, and, as noted by Respondent, was not in any acute respiratory distress. (Ex. 6, pp. 118–120, A178–A180.) He too observed Patient 1's chest x-ray taken on December 5 showed an increased bilateral effusion but there no change on December 6. On December 6, Dr. Kwun continued to express uncertainty as to the cause of Patient 1's pleural effusions. He stated, "a thoracentesis to differentiate transudate or exudate would be advisable, although based on her age, family requested conservative management." (*Id.* at p. 119, A179.) He ordered the present treatment to continue, although he believed the prognosis to be "poor." (*Ibid.*)

27. The December 7, 2016 notes from Dr. Kwun, Dr. Rao, and Respondent all observe Patient 1 to comfortable and in no respiratory distress. Dr. Kwun reported Patient 1 said she felt better and denied chest pain or shortness of breath, and indicated he may start diuretic treatment based on the progressive increase in pleural effusion. (Ex. 6, p. 121, A181.) Dr. Rao noted Respondent had started Patient 1 on steroids and her ABG results were better. According to Dr. Rao, the plan was to "continue present management – ABG done today is better with $pCO2^3$ coming down to normal and the patient has been switched from IV Solu-Medrol to oral prednisone." (*Id.* at pp. 439–440, A499–A500.) The radiologist reported no changes in Patient 1's effusions since December 5, 2016. (*Id.* at pp. 96–97, A156–A157.)

28. Respondent's pulmonary progress note for December 7, 2016, reflected Patient 1 was examined at 8:51 a.m.; NP Mutuc electronically signed the note at 8:53 a.m. The note also reflected it was amended at 12:43 p.m. (Ex. 6, p. 441, A501.) The note describes Patient 1 as awake and in no respiratory distress. (*Ibid.*) Respondent

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[3] Partial pressure of carbon dioxide.

testified he later amended the note to state that Patient 1's daughter was at her bedside, and "except for sputum production, the patient has no further complaints." (*Id.* at p. 443, A503.) The capitalized portion added by Respondent states Patient 1 is very weak and not ambulatory, and, therefore, placement in a nursing home is being considered for rehabilitation, including physical therapy, and to optimize her pulmonary status. Respondent testified he often placed his notes in capitals. He electronically signed the note at 12:44 p.m., immediately after the amendment, indicating the amendment was his. (*Ibid.*)

29. The December 8, 2016 pulmonary progress note reflected Patient 1 was comfortable and asleep, with no shortness of breath. (Ex. 6, p. 449, A509.) The note indicates that Patient 1's treatment plan now includes "snf [skilled nursing facility] placement." (*Id.* at p. 451, A511.) The nursing orders state that Respondent approved the discharge of Patient 1 to a skilled nursing facility later that day. (*Id.* at p. 330, A390.)

30. Dr. Kwun's examination of Patient 1 on December 8, 2016, also found her alert, oriented, and "very comfortable." (Ex. 6, p. 122, A182.) His note repeated his previous impression that "thoracentesis is advised, but family requested conservative management." (*Ibid.*)

31. On December 8, 2016, Patient 1 was deemed stable, and she was discharged to a skilled nursing facility. No thoracentesis was performed during her stay. (Ex. 6, p. 55, A115.) In his discharge summary, Dr. Rao noted Patient 1 was much improved and doing much better. (*Id.* at p. 456, A516.) He instructed the present management of Patient 1, as per pulmonary and cardiac consultants, to be continued. Dr. Rao also noted that both pulmonary and infectious disease consultants approved the nursing home placement. (*Ibid.*) There is no evidence that Dr. Kwun or any of

Patient 1's other treating or consulting doctors voiced any disagreement with the discharge order.

32. Physical therapy notes of Patient 1's treatment during her hospital stay indicate Patient 1's movements were limited by her age and obesity. (Ex. 6, p. 323, A383.) She needed two people to assist her to sit at the edge of the bed and required upper and lower torso assistance. (*Id.* at p. 324, A384.)

33. The pulmonary progress notes signed by Respondent reflect numerous instances of cutting and pasting portions of previous notes. (See e.g., Ex. 6, pp. 410–411, 418–419, 422–423, 426–428; 431–433, 436–438, 441–443, 449–451, A470–A471, A478–A479, A482-A483, A486–499, A491–493, A496–498, A501–A502, A509–A511.) The notes all erroneously reflect that Patient 1 had a fever, although she was afebrile, and repeat the same assessment contained in Respondent's November 30 note. (*Ibid.*) The notes from December 1 through December 3 contain the same descriptions in the "physical examination" section of Patient 1's respiratory function, i.e., an examination of her lungs revealed, "bilateral wheezes bilaterally upon auscultation." (*Id.* at pp. 410, 418, 422, A470, A478, A482.) The notes from December 5 through December 7 repeat the same physical examination results from Respondent's December 4 note. (*Id.* at pp. 431, 436, 441, A491, A496, A501.) Additionally, the notes do not refer to any of Patient 1's x-rays except those taken on December 1 and December 5 and fail to mention the CT or electrocardiogram results. The notes also fail to identify whether Respondent was present during Patient 1's examinations or fully explain Respondent's thought processes supporting his treatment decisions during Patient 1's first hospital stay.

34. NP Mutuc did not have any independent recollection of Patient 1. NP Mutuc acknowledged she prepared the notes for all of Patient 1's examinations during her first hospital stay except for Respondent's December 4 examination. She had no

explanation as to why the notes did not include Patient 1's CT scan or complete x-ray results. She acknowledged the notes had mistakenly stated Patient 1 had a fever when she did not and she had cut and pasted several portions of the notes from earlier notes.

Second Admission

35. Patient 1 was readmitted to GEMCH for "weakness" and mild hypoxia on December 29, 2016. (Ex. 6, p. 506, A566.) The ER physician found no signs of cough, shortness of breath, or respiratory distress. (*Id.* at p. 631, A691.) Patient 1 was diagnosed with multisystem failure, including pleural effusions, congestive heart failure, uremia, generalized weakness, and hyperglycemia, with a history of hypertension and diabetes. (*Id.* at p. 634, A694.) Dr. Rao was again assigned to be her attending physician.

36. A chest x-ray taken on the date of her admission (December 29) showed no significant change from Patient 1's chest x-ray taken on December 7, 2016. (Ex. 6, p. 637, A697.) According to the radiologist's findings, Patient 1's x-rays continued to show a minimal right pleural effusion and a moderate to large left pleural effusion with compressive atelectasis and persistent cardiomegaly with interstitial pulmonary edema. (*Id.* at p. 554, A614.)

37. In his initial examination of Patient 1 on December 30, 2016, Dr. Rao's examination found no cough, shortness of breath, or wheezing. Her lungs were clear bilaterally with no retractions and normal respiratory effort. Dr. Rao planned to treat Patient 1 with bronchodilators and consult with pulmonary and cardiology. He also noted that Patient 1 was DNR. (Ex. 6, pp. 635–637, A695–A697.) Hospital records

indicate Patient 1's family requested that no compressions, defibrillation, or intubation be performed; they consented to only chemical intervention. (*Id.* at p. 548, A608.)

38. On December 30, 2016, a chest x-ray taken of Patient 1 showed significant changes. The radiologist's impression was a complete opacification of Patient 1's left hemithorax, increased since the previous day's x-ray, "likely reflecting massive left pleural effusion with adjacent atelectasis or left lung collapse." (Ex. 6, p. 555, A615.) The radiologist noted Patient 1's heart size was enlarged, and he found a stable small volume right pleural effusion with moderate pulmonary edema and cardiomegaly as well as atherosclerotic vascular disease. (*Ibid.*)

39. Nagasamudra S. Ashok, M.D., specializing in internal medicine, was requested to consult on the case. His notes reflect the December 30 x-ray changes. According to his plan, "patient will benefit from urgent bronchoscopy. Otherwise chest tube . . IV [antibiotics], sputum [culture], Lasix will be helpful, accu check insulin coverage, monitor vitals, diet, f/up pulmonary consult, f/up labs." (Ex. 6, p. 641, A701.)

40. Respondent was again asked to consult on Patient 1's case. In response to the change reflected in Patient 1's December 30 x-ray, Respondent performed a fiber-optic bronchoscopy on Patient 1 that same day. The procedure had no complications. According to Respondent's notes, he observed thick tenacious mucus plugs occluding the left mainstem bronchus, which he successfully suctioned. The post suctioning endobronchial anatomy on the left side and right was normal. (*Id.* at p. 643, A703.)

41. Although Respondent considered the procedure a success, a subsequent x-ray ordered by Respondent and taken at 4:00 a.m. on December 31, 2016, showed no change in the opacity of Patient 1's left lung. According to the radiologist, there

was a "complete white out of the left lung . . . consistent with a large pleural effusion" and a "persistent small right pleural effusion with compressive atelectasis." (Ex. 6, p. 557, A617.)

42. The pulmonary progress note dated December 31, 2016, observed Patient 1 to be awake and alert, denying shortness of breath. (Ex. 6, p. 647, A707.) Patient 1 was found to have a "normal respiratory effort" with "lungs clear bilaterally." (*Ibid.*) The note highlights the radiologist's finding of a complete white out of Patient 1's left lung and states there was "no significant improvement in the x-ray because of pleural effusion." (*Id.* pp. 648–649, A708–A709.) Respondent's plan is for "supplemental oxygen, bronchodilators, continue ivabx [iv antibiotics]." Respondent amended the note at 4:19 p.m., and added the following in all capital letters: "Patient will need thoracentesis and this will be discussed with the patient and will be scheduled accordingly." (*Ibid.*)

43. On December 31, 2016, at 11:16 a.m., a nurse called Respondent regarding a critical value of CO2 of 41 for Patient 1. Respondent returned the call but gave no orders. (Ex. 6, pp. 590–591, A650–A651.) Respondent testified he did not do so because the increased CO2 value was not indicative of any pulmonary dysfunction and he needed to examine the patient before initiating any new treatment.

44. On January 1, 2017, Dr. Rao examined Patient 1 at 1:54 a.m. According to his note, he found no acute distress, Patient 1's vital signs were normal, and her lungs were clear. Dr. Rao states Patient 1 will need a thoracentesis because her condition has not improved after the bronchoscopy. (Ex. 6, p. 652, A712.)

45. According to the nursing notes, on the morning of January 1, 2017, Patient 1's oxygen saturation was 98 percent. She had no fever, no shortness of breath,

and exhibited no respiratory or other distress. (Ex. 6, pp. 594, 595, A654, A655.) At 8:21 a.m., the floor nurse again informed Respondent by telephone of a critical CO2 value of 46 in Patient 1's laboratory tests. Respondent made no new orders at that time. (*Id.* at p. 596, A656.) Respondent testified he did not do so for the same reason he made no orders in response to the December 31 telephone call. Respondent was not alerted that Patient 1 was in any discomfort or distress, and therefore concluded any new orders could wait until after he examined Patient 1.

46. At 10:11 a.m. on January 1, 2017, a Code Blue was called when Patient 1 was found "unresponsive with agonal breathing." (Ex. 6, p. 549, A609.) Patient 1 regained a "weak pulse," and she was transferred to the ICU. (*Ibid.*) A second Code Blue was called at 10:28 a.m., and Patient 1 was declared dead at 10:31 a.m. on January 1. (*Id.* at p. 545, A605.) In his discharge summary, Dr. Rao noted Patient 1 "appeared stable before her death and then suddenly stopped breathing." (*Id.* at p. 654, A714.)

RESPONDENT'S TESTIMONY

47. Respondent did not have any independent recollection of Patient 1. Based on his review of the records, he described his primary objective for Patient 1 was to help her breathe easier and treat her cough. During Patient 1's first hospital stay, Respondent managed her care by prescribing IV steroids and respiratory treatment. He did not believe a thoracentesis was necessary during that time because Patient 1's respiratory condition was stable, her oxygenation was good, and her cough was productive and had not worsened. Respondent did not believe the presence of pleural effusions indicated Patient 1 needed to stay at GEMCH. He did not discuss performing a thoracentesis with Patient 1's family because there was no need to perform the procedure considering Patient 1's stable condition and the absence of respiratory

distress, which Respondent asserted was confirmed by her 22 days stay at the skilled nursing facility without incident after her discharge from GEMCH.

48. After Patient 1 was readmitted to GEMCH at the end of December 2016, Respondent was still of the belief she did not need a thoracentesis because the initial chest x-ray showed no change since her last stay. However, the changes in her December 30 x-ray immediately prompted him to do a bronchoscopy. He believed the whiteout of Patient 1's lung was because her weak condition had made it difficult to cough up and clear mucous. He thought it prudent to perform a bronchoscopy before a thoracentesis to make sure Patient 1 had no bronchial obstruction. He performed the bronchoscopy as soon as he received Patient 1's family consent and the required staff and ICU room were ready.

49. Respondent believed the bronchoscopy to be successful because he was able to remove the mucous plugs, notwithstanding the follow-up x-ray showing the continued whiteout of Patient 1's lungs. Respondent explained it was not uncommon for patients undergoing a bronchoscopy to not be able to clear all of the mucous immediately.

50. According to Respondent, the need to perform a thoracentesis after completing the bronchoscopy was not emergent because Patient 1's vital signs were stable, she was not in respiratory distress, her oxygen saturation was high, and she evidenced no shortness of breath. However, because of the continued opacity of Patient 1's lung, he believed the procedure should be considered as a treatment option and the risks and benefits of performing the procedure should be discussed with the family.

51. Respondent testified he was made aware of Patient 1's elevated CO2 rates on December 31, 2016, and January 1, 2017. However, he asserted there were many reasons why Patient 1's CO2 rates were high, and that patients receiving diuretics, like Patient 1, often have high CO2 rates. Respondent further asserted a high CO2 rate did not suggest Patient 1 was in respiratory distress or a thoracentesis was warranted.

52. Respondent testified he takes care of his patients as he would do his family. His credo is that a doctor should not cause harm by performing a procedure that will do no good. He explained he had performed thousands of thoracenteses during his decades of practice but only when they were necessary. Respondent believes a thoracentesis is an invasive, potentially risky procedure, and Patient 1's obesity, weakness, and inability to sit unassisted increased its risks. Respondent did not believe the procedure was necessary during Patient 1's first hospital admission because non-invasive treatments were working, and Patient 1 passed away before he could perform the procedure during her second admission.

53. Respondent acknowledged it was his responsibility to review the progress notes dictated by NP Mutuc. He did not dispute that the notes contained errors, omissions, and replicated portions of earlier notes. He testified he had little experience with electronic recordkeeping during the period he treated Patient 1.

EXPERT TESTIMONY – MANAGEMENT OF PATIENT 1'S PLEURAL EFFUSION

54. Dr. Shrivastava stated the standard of care requires that a pleural effusion be drained and a fluid analysis be performed to differentiate between the transudate and the exudate. According to Dr. Shrivastava, the nature of the pleural fluid facilitates the diagnosis, management, and prognosis of a patient. If the procedure cannot be

done for any reason, Dr. Shrivastava believed the standard of care required the matter to be discussed with the patient and family and documented in the patient records explaining the rationale behind the decision, as well as alternative plans. Dr. Shrivastava opined Respondent's failure to drain Patient 1's pleural effusion and perform a diagnostic fluid analysis, his failure to discuss the option of thoracentesis with Patient 1's family, and his failure to document his reasons for his decision not to go forward with the procedure constituted an extreme departure from the standard of care. (See Ex. 5, pp. 3–4, A59–A60.)

55. Dr. Brooks disagreed with Dr. Shrivastava's opinion regarding the standard of care in this case. According to Dr. Brooks, the standard of care articulated by Dr. Shrivastava ignored the individual aspects and complexities attendant in Patient 1's case, specifically her age, obesity, and immobility as well as a documented status for conservative management of her condition. According to Dr. Brooks, the standard of care required Patient 1's effusion to be managed conservatively and Respondent's conduct comported with that standard. (See Ex. E, pp. 1–3, B1069–B1071.)

56. Dr. Brooks explained that a thoracentesis could be performed for diagnostic or therapeutic reasons, and he opined that the standard of care did not require Respondent to perform a thoracentesis for either purpose during Patient 1's first hospital stay. A diagnostic thoracentesis was unnecessary because Patient 1 was already being treated for all possible causes for the effusion, i.e., IV antibiotics if it was due to an infection and diuretics if the cause was due to a cardiac condition. Thus, there was no need to obtain the pleural fluid to differentiate between the exudate or transudate because both were already being addressed in Patient 1's treatment.

57. Dr. Brooks opined the standard of care also did not require Respondent to perform a therapeutic thoracentesis during her Patient 1's first stay because of her

physical condition and her family's request for conservative treatment. He explained Patient 1 could not sit upright for an extended time, which was required to safely perform the procedure, she was not in respiratory distress, and her oxygen saturation rate and ABG results were normal at the time of her discharge. Thus, he opined the risks of performing a thoracentesis outweighed any benefits the procedure might yield. He also testified that discharging Patient 1 with a pleural effusion to a skilled nursing facility was not contrary to the standard of care.

58. Dr. Brooks disagreed with Dr. Shrivastava's opinion that the standard of care required Respondent to have performed a thoracentesis immediately after the bronchoscopy. He asserted there was no pressing need to perform the procedure considering the stability of Patient 1's vital signs and the absence of any respiratory distress. According to Dr. Brooks, performing a thoracentesis on Patient 1 also presented difficulties because her obesity made it difficult to determine where to place the needle and she was in "full assist," meaning that three people would have to hold her in place during the procedure.

59. Dr. Brooks further disputed Dr. Shrivastava's assertion that Respondent had a duty to discuss his decision not to perform a thoracentesis with the family during Patient 1's first hospital stay. Dr. Brooks asserted it was within the standard of care for a physician to not discuss with the family or the patient procedures the physician was not considering.

ANALYSIS

60. Dr. Brooks' opinion was more persuasive than Dr. Shrivastava's opinion for several reasons. First, it was tailored to the individual circumstances presented by Patient 1. The standard of care articulated by Dr. Brooks considered Patient 1's

weakness, her obesity, her immobility, and her family's desire for conservative management of her condition. Dr. Brooks also considered the purpose and impact of performing a thoracentesis on Patient 1, and how the results would affect her treatment. In contrast, Dr. Shrivastava articulated a standard of care that did not consider these factors. He did not consider the dangers of a thoracentesis for Patient 1 or how the results of a thoracentesis would impact Patient 1's care. He failed to address the need or urgency of performing a thoracentesis given the absence of any evidence that Patient 1 was in respiratory distress, the treatment that Patient 1 was already receiving, and the family's request for conservative treatment.

61. Second, Dr. Shrivastava's opinions were inconsistent. Although in his testimony Dr. Shrivastava initially opined Respondent should have performed a thoracentesis during Patient 1's first hospital stay or documented his reasons for not doing so, he also testified he "respected" Respondent's decision to perform a bronchoscopy before a thoracentesis during Patient 1's second stay. However, if Dr. Shrivastava believed Respondent acted contrary to the standard of care in not performing a thoracentesis during Patient 1's first stay, then it would seem to follow that the standard of care required Respondent to immediately perform the procedure upon Patient 1's readmission. Dr. Shrivastava's testimony stating otherwise undercuts his assertion Respondent acted contrary to the standard of care by failing to perform a thoracentesis during Patient 1's first hospital stay. Thus, it appears Dr. Shrivastava's only complaint is that Respondent failed to perform a thoracentesis immediately after he performed the bronchoscopy. However, Dr. Shrivastava failed to provide convincing testimony as to why the procedure was urgent considering Patient 1's stable vital signs and lack of respiratory distress.

62. Third, Dr. Shrivastava's report contained several misstatements of the record. Contrary to Dr. Shrivastava's statement that Respondent did not consider a thoracentesis after noting the lack of improvement after the bronchoscopy (Ex. 5, p.3, A59), Respondent's December 31 progress note states he would consider thoracentesis after he speaks with the family. (Ex. 6, p 649, A709.) Dr. Shrivastava also suggests Respondent was ignorant of Patient 1's CT scan results because his progress notes do not mention those results (Ex. 5, p.3, A59); however, Respondent's December 5 progress note reflects that he discussed with Patient 1's family the results of the CT scan (Ex. 6, p. 426, A486).

63. Fourth, Dr. Shrivastava's conclusion that Respondent's failure to perform a thoracentesis contributed to Patient 1's death was not supported by the evidence. The medical records indicate Patient 1's vital signs and oxygenation were stable up to an hour before she experienced cardiac arrest. (Ex. 6, pp. 594, 595, A654, A655.) Dr. Rao, in his discharge report, confirmed Patient 1 was stable before her death and did not indicate her pleural effusions contributed to her demise. (*Id.* at p. 654, A714.) Dr. Shrivastava's opinion that Patient 1's increased CO2 levels indicated respiratory distress was also discredited by both Dr. Brooks and Respondent.

64. The evidence further supports Dr. Brooks' opinion that Respondent acted consistently with the standard of care. None of Patient 1's treating or consulting doctors disagreed with Respondent's treatment of Patient 1 during her first or second stay. None of the doctors questioned Respondent's approval of Patient 1's discharge to a nursing facility. Although Dr. Kwun repeatedly noted that a thoracentesis "might" be necessary for diagnostic purposes, he never indicated it was mandatory and acknowledged it would be contrary to the family's wishes. The records also evidence his agreement with Respondent's decision to treat Patient 1 with increased steroids.

65. Based on the foregoing, Complainant did not establish Respondent's management of Patient 1's condition constituted an extreme departure from the standard of care.

EXPERT TESTIMONY – ALLEGED FAILURE TO RECOGNIZE DETERIORATION OF PATIENT 1'S MEDICAL CONDITION

66. The Accusation alleges Respondent was negligent because he "failed to recognize the deterioration of Patient 1's medical condition during the time periods he allowed [NP Mutuc] to provide care and treatment to Patient 1." (Accusation, ¶ 46B.)

67. Dr. Shrivastava did not opine that Respondent departed from the standard of care because he failed to recognize the deterioration of Patient 1's medical condition. According to Dr. Shrivastava, the standard of care required Respondent to provide appropriate supervision over NP Mutuc, communicate regularly with NP Mutuc, and oversee NP Mutuc's practice and quality of care. Dr. Shrivastava opined Respondent departed from this standard of care because it was not clear from Patient 1's medical records whether Respondent saw or examined Patient 1 and what level of supervision Respondent provided to NP Mutuc, "especially in a patient who was gradually deteriorating." (Ex. 5, p. 4, A60.)

68. Dr. Brooks did not dispute Dr. Shrivastava's articulation of the standard of care regarding the relationship between physicians and their nurse practitioners. However, he disputed Dr. Shrivastava's characterization of Patient 1 as "gradually deteriorating." (Ex. E, p. 3, B1071.) According to Dr. Brooks, Patient 1's vital signs and oxygenation "were consistently stable despite the pleural effusion" and Patient 1 "remained clinically stable until the acute event took place resulting in her expiration."

(*Ibid*, italics in original.) Thus, Dr. Brooks asserted the Accusation's allegation that Respondent failed to recognize Patient 1's deteriorating condition was invalid. (*Ibid.*)

ANALYSIS

69. Complainant offered no evidence that NP Mutuc provided care or treatment to Patient 1 without Respondent's supervision as alleged in the Accusation; the absence of any reference in the progress notes as to who performed the examinations does not establish Respondent did not perform the examinations. Both Respondent and NP Mutuc testified they met together each morning to review Patient 1's case and treatments and it was their custom and practice to examine Respondent's patients together; NP Mutuc also testified she only dealt with a patient under the supervision of a doctor.[4] Dr. Shrivastava's opinion that Respondent failed to exercise appropriate supervision over NP Mutuc is therefore contrary to the evidence.

70. The evidence adduced at hearing also demonstrates, contrary to Complainant's charge, that Respondent was aware of Patient 1's condition through his daily meetings with NP Mutuc during which he reviewed laboratory and test results, his examinations of Patient 1, and his review of NP Mutuc's progress notes. Respondent's December 4 note makes clear he was aware of previous tests performed on Patient 1; the December 5 progress note, which was co-signed by Respondent, includes the x-ray report showing enlargement of the effusion; and Respondent added

[4] Disbelief does not create affirmative evidence to the contrary of that which is discarded. (*Hutchinson v. Contractors' State License Bd. of Cal.* (1956) 143 Cal.App.2d 628, 632–633, quoting *Marovich v. Central Cal. Traction Co.* (1923) 191 Cal. 295, 304.)

his own observations of Patient 1's condition to the December 7 progress note. (See Factual Findings 24, 25, & 28.)

71. The assumption that Patient 1's condition was gradually deteriorating is also a matter of dispute between Dr. Shrivastava and Dr. Brooks. Although Patient 1's effusion became larger during Patient 1's first hospital stay as Dr. Shrivastava noted, it was not made clear that Patient 1's change in condition constituted a "gradual deterioration." Dr. Brooks pointed out that Patient 1's vital signs and oxygenation were stable at the time of her discharge, her condition was stable, and she showed no discomfort. According to Dr. Brooks, a patient can tolerate pleural effusions quite well, and their presence was not determinative of Patient 1's condition. Dr. Brooks' opinion cannot be discounted.

72. Based on the foregoing, Complainant did not establish that Respondent departed from the standard of care by failing to recognize any deterioration of Patient 1's condition.

TREATMENT OF PATIENT 2

73. On July 8, 2017, Patient 2, a 44-year-old woman, was admitted to GEMCH to treat a gall bladder condition. (Ex 11, p. 3, A747.) Her admitting diagnosis was "calculus of gall bladder with acute cholecystitis without obstruction." (*Id.* at p. 4, A748.) Respondent was assigned to be Patient 2's attending physician.

74. During her hospital stay, Patient 2 was admitted to the medical/surgery unit. Respondent examined Patient 2 on July 8, 2017. (Ex. 11, p. 128, A871.) The note dictated by NP Mutuc assesses Patient 2 with acute cholecystitis with cholelithiasis urinary tract infection and leukocytosis. The plan was for Patient 2 to undergo a surgical consult.

75. On July 8, 2017, Miyata Shin, M.D., performed a surgical examination of Patient 2. He recommended a laparoscopic cholecystectomy secondary to acute cholecystitis. (Ex. 11, pp. 129-130, A873-A874.) The next day, on July 9, 2017, Dr. Shin performed a laparoscopy cholecystectomy on Patient 2, which she tolerated well. (Ex. 11, p. 133, A877.)

76. Respondent examined Patient 2 on July 10, 2017. The progress note indicated Patient 2 felt much better after her surgery and was in less pain. (Ex. 11, p. 135, A879.). The note recommends discharge planning for the following day. (*Ibid.*)

77. That same day, both Respondent and NP Mutuc ordered a basic metabolic panel for Patient 2 to be scheduled for the following day, July 11, 2017. (Ex. 11, p. 109, A853.) The panel was performed at 5:30 a.m. on July 11, and the lab published the results at 9:40 a.m. that same day. The results showed Patient 2's creatinine level was 1.97, an increase from 0.87 the day before. A range of 0.60 to 1.30 mg/dL is considered normal; elevated levels signify possible kidney malfunction or failure. (*Id.* at p. 118, A862.)

78. At 10:15 a.m., NP Mutuc with Respondent's approval, discharged Patient 2. In her discharge summary dictated at 10:15 a.m. and electronically signed at 10:16 a.m., NP Mutuc stated Patient 2 had tolerated the surgical procedure well and had been cleared for discharge by her surgeon. The note stated Patient was in "fair condition" and was going home. Patient 2 was instructed to follow up with her surgeon in one to two weeks. (Ex. 11, p. 47, A791.) The note did not refer to the results of the laboratory testing performed earlier that morning, including the elevated creatinine level.

79. Complainant offered no evidence demonstrating either Respondent or NP Mutuc were made aware of or had any knowledge of Patient 2's July 11 creatinine test result before approving Patient 2's discharge. Nor was there any evidence showing Respondent was made aware of the test result after Patient 2 was discharged.

80. On July 14, 2017, Patient 2 was readmitted to GEMCH complaining of abdominal pain. Patient 2 was diagnosed with a gallbladder fossa abscess, which was drained. (Ex. 11, p. 205, A949.). During her stay, Patient 2's creatinine levels increased to 7.8. A Foley catheter was placed a day or two after her admission, and her creatinine came down to normal limits. (*Id.* at p. 209, A953.) The urology consult considered Patient 2's creatinine levels to be an unusual occurrence likely due to significant constipation from Patient 2 taking opioids to control her post-surgical pain. (*Ibid.*) The Foley catheter was eventually removed from Patient 2, and the issue resolved by July 21, 2017, when Patient 2 was discharged. Patient 2's creatinine level at the time of discharge was within normal limits, i.e., 0.91. (*Id.* at p. 337, A1081.).

81. Respondent had no independent recollection of Patient 2. He testified although he ordered the laboratory tests, it was NP Mutuc's or the nursing staff's responsibility to notify him of the laboratory's findings, particularly any abnormal laboratory result, and he only became aware of an abnormal laboratory test result if a nurse or NP Mutuc notified him. He also relied on NP Mutuc to let him know if the laboratory results were still pending. If he had known of the creatinine test result before Patient 2's discharge, Respondent asserted he would still have discharged her considering her age, her adequate intake of liquids during her stay, and the expected follow-up with her surgeon. However, Respondent testified he would have included in Patient 2's discharge instructions a direction to drink lots of fluids. He pointed out that Patient 2's surgeon, who was her primary treater during her stay, cleared her for

discharge and Patient 2 was to follow-up with her surgeon if any problems arose. Respondent was not aware of Patient 2's readmission.

82. NP Mutuc also had no independent recollection of Patient 2. She testified it would have been her custom and practice to include the creatinine test results in her note or discuss the results with Respondent if she had been aware of them. According to NP Mutuc, it was not uncommon for there to be a delay in reporting the laboratory results to the nurses.

EXPERT TESTIMONY – PATIENT 2'S ABNORMAL LABORATORY RESULTS

83. Both Dr. Shrivastava and Dr. Brooks opined regarding the standard of care concerning Respondent's responsibility to recognize and address Patient 2's abnormal laboratory results.

84. According to Dr. Shrivastava, the standard of care requires that a patient only be discharged after a review of their current vital signs as well as their current and pending laboratory results, and any abnormal values must be addressed before discharge. Dr. Shrivastava also noted that patients can be discharged with abnormal laboratory values if adequate follow-up plans are provided to the patient. (Ex. 10, p. 3, A744.) Dr. Shrivastava asserted Respondent overlooked Patient 2's abnormal creatinine levels when he agreed to her discharge, and his conduct constituted a simple departure from the standard of care. (*Ibid.*)

85. Dr. Brooks disagreed with Dr. Shrivastava's conclusion and opined Respondent did not act contrary to the standard of care when he discharged Patient 2. (Ex. E, p. 3, B1071.) He pointed out that although NP Mutuc discussed Patient 2's case with Respondent, she did not communicate that either laboratory results were pending or that results showed an abnormal creatinine result. He also asserted Respondent

never received any notification of the abnormal laboratory result from nursing or laboratory staff. Dr. Brooks believed it was appropriate for Respondent to rely on NP Mutuc to alert him to the status of laboratory tests and abnormal test results.

ANALYSIS

86. Under the circumstances presented here, Dr. Brooks' opinion is deemed more persuasive. Dr. Shrivastava's opinion did not acknowledge the custom and practice at GEMCH for nurses and nurse practitioners to alert doctors to abnormal laboratory results. The medical records showed that in two separate instances, Respondent was informed of abnormal laboratory results for Patient 1 by nursing staff, and on July 10, 2017, a nurse telephoned Respondent with laboratory results regarding Patient 2. (See Ex. 6, pp. 596, 590-591, A650-A651, A656; Ex. 11, p. 94, A838.) Dr. Shrivastava's opinion also failed to acknowledge Respondent's reliance on NP Mutuc to share the status of laboratory testing and results. Respondent acted reasonably in relying on NP Mutuc to alert him to this information. Accordingly, Complainant did not establish by clear and convincing evidence that Respondent's failure to act on the creatinine abnormal test result or delay Patient 2's discharge before receiving the full laboratory results constituted a simple departure from the standard of care.

Evidence of Rehabilitation and Mitigation

87. Respondent is a solo practitioner dedicated to the care and treatment of his patients. He works seven days a week and is on call 24 hours a day. Notwithstanding the age-related risks of exposure to Covid-19, Respondent worked every day since the onset of the Covid-19 pandemic as the only pulmonologist serving GEMHC. He treated over 450 Covid-19 patients during this time.

88. Respondent is active in the administration of the hospitals where he has worked. He has served on the Medical Executive Committee of Beverly Hospital, Kindred Hospital, and GEMCH. At Beverly Hospital, he served as the Patient Safety Chairman from 2017 to 2018 and 2019 to 2021, and on the peer review committee. At GEMCH, he served two terms as Chief of Staff; he also served as chairperson of the ICU team, the Department of Medicine, and the Credentials Committee.

89. Respondent has won several awards for his service to the community. (Ex. Q.) In 2020, Respondent received a certificate of appreciation from GEMCH in recognition of his excellent patient care. (Ex. C., p. 2, B1064.) In June of 2018, he received the Beverly All-Star Physician Award for providing outstanding quality and competent care to Beverly Hospital patients and the community. In 2018, Respondent received another certificate from Beverly Hospital in recognition of his outstanding work and dedication to patient safety. He was also recognized by State Senator Tony Mendoza and State Assemblymember Cristina Garcia for his work in establishing the neo-natal ICU at Beverly Hospital.

90. Respondent has never been subject to Board discipline. He has never settled or paid any malpractice claims.

91. The physician whose complaints triggered the Board's investigation of Respondent also complained to GEMCH regarding Respondent's conduct. GEMCH launched an investigation of the complaints in 2017. In response, GEMCH placed Respondent on Focused Professional Practice Evaluation Review (FPPE) for six months, from July 1 to December 1, 2018, during which a team reviewed 60 randomly selected charts for Respondent's patients. After reviewing the selected charts, the review team found that Respondent was "performing well or within desired expectations" and no further action was warranted. The review team also recommended the continuation of

Respondent's current privileges at GEMCH and the termination of the formal evaluation process. (Ex. 14, p. 27, A1280.)

92. Respondent has the support of his colleagues and patients who provided letters of reference and testified on his behalf. They collectively described Respondent as trustworthy, diligent, caring, devoted to patients, and an asset to the community. (Exs. F–O, R.)

A. Stanley Toy, Jr., M.D., who is currently the Chief Executive Officer at GEMCH and has known Respondent for over 20 years, testified at the administrative hearing and submitted two letters on Respondent's behalf. Dr. Toy lauded Respondent's dedication and commitment to the community during the COVID-19 pandemic. According to Dr. Toy, Respondent was a leader in Covid-19 care and management at GEMCH and was an inspiration to the hospital staff. In a letter dated March 17, 2021, Dr. Toy described Respondent as "indispensable, spending countless hours working 10-12 hours a day on an average every single day of the year with no exception, putting in extra hours, and making himself available 24/7 for all emergency phone calls from the hospitals" and wrote that Respondent "always went far and beyond the call of duty." (Ex. G, p. 1, B1075.) In an earlier letter to the Board, dated April 20, 2020, Dr. Toy wrote:

> In my capacity as a practicing physician, I have known [Respondent] for over 20 years. I have referred scores of patients to [Respondent] from ER for various medical issues and have served with [Respondent] on various Medical Staff Committees at GEMCH. In my interactions with [Respondent], he has always been engaging, candid and focused on his task at hand. His standard of care has been

> beyond reproach[] and his dedication to his community has always been exceptional.
>
> [¶] . . .[¶]
>
> GEMCH is considered a safety net hospital in County of Los Angeles providing medical care to a medically underserved community comprised of a large section of Medi-Cal and Uninsured patients. Despite this payor mix, [Respondent] has assisted without hesitation in providing services to this community. [Respondent] has always demonstrated highest integrity and in his care to his patients has always met community standards. His standard of care has rarely been questioned by his peers. He has received positive comments via his patients, social media and personal recognition from various medical and healthcare organizations.....[Respondent's] reputation as a medical provider in our community is held in high regards while at GEMCH .....[Respondent] is currently our only active practicing Pulmonologist at GEMCH. He has been actively participating in the care of COVID-19 patients during this pandemic crisis. The hospital and its community need[] for him to continue to be an active member of our Medical Staff as this is paramount to providing quality care to our community.

(*Id.* at pp. 2–3, B1076–B1077.)

B. Victor R. Lange, Ph.D., J.D., and Director of Quality, Risk Management, and Infection Prevention at GEMCH, testified on Respondent's behalf and also submitted a letter. He has known Respondent for more than three years through his work at GEMCH. Dr. Lange wrote of Respondent's "exceptional clinical abilities," as well as his "excellent knowledge, patient care, and leadership." Dr. Lange noted that patients described Respondent as "loving, sincere, honest, loyal and unselfish." He observed that Respondent has been revered for his professionalism, and is respected by and is an inspiration to hospital staff, particularly for his dedication during the Covid-19 pandemic. (Ex. R.)

C. John Stewart, M.D., is a family medicine practitioner and Chairman of the Board of Alhambra Medical Center. He has known Respondent as a primary consultant in pulmonary and critical care medicine for over 30 years. Dr. Stewart testified and wrote a letter on Respondent's behalf. (Ex. O.) According to Dr. Stewart, he has always been able to effectively communicate with Respondent about the care, prognoses, and management of his patients. He has repeatedly trusted Respondent with his own family's care and noted Respondent's commendable attitude.

93. Respondent testified in a straightforward, credible manner. He answered questions directly, did not belabor or embellish his testimony, and his explanations for events that occurred were reasonable. Respondent was extremely knowledgeable regarding the topics covered and presented as a thoughtful, caring, and careful physician. He took responsibility where he believed his actions were remiss. He did not blame NP Mutuc for any gaps or inaccuracies in the progress notes and did not dispute his obligation to train and supervise NP Mutuc. Respondent made changes to his charting practices as soon as the issues became apparent, as confirmed by the

GEMCH review team. He also no longer employs nurse practitioners to avoid any further confusion regarding his practices.

LEGAL CONCLUSIONS

1. The standard of proof that must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit, and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

2. After an administrative hearing, the Board has the authority to revoke, suspend, place on probation. or publicly reprimand a licensee who has engaged in unprofessional conduct. (Bus. & Prof. Code,[5] § 2227.) Unprofessional conduct includes gross negligence, repeated negligent acts, and the failure to maintain "adequate and accurate records relating to the provision of services." (§§ 2234, subds. (b), (c), 2266.)

3. "Gross negligence" has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1185–1186.) Complainant did not establish by clear and convincing evidence that Respondent committed gross negligence in his care and treatment of Patient 1's pleural effusions.

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[5] All statutory references are to the Business and Professions Code unless otherwise stated.

(Factual Findings 1–65.) Cause therefore does not exist to discipline Respondent's certificate for gross negligence under section 2234, subdivision (b).

4. "Repeated negligent acts" is defined as two or more acts of negligence. (*Zabetian v. Medical Bd. of Cal.* (2000) 80 Cal.App.4th 462, 468. Complainant did not establish by clear and convincing evidence that Respondent committed repeated acts of negligence in his care and treatment of Patient 1 or Patient 2. Complainant failed to establish that Respondent committed negligence in his treatment of Patient 1's pleural effusions or his supervision of NP Mutuc. (Factual Findings 1–72.) Nor was there sufficient evidence to establish Respondent was negligent in failing to recognize or address the laboratory result showing increased creatinine when discharging Patient 2. (Factual Findings 1–12, 73–86.) Cause therefore does not exist to discipline Respondent's certificate for repeated acts of negligence under section 2234, subdivision (c).

5. Complainant established by clear and convincing evidence that the progress notes for Patient 1 signed by Respondent were inaccurate and inadequate. (Factual Findings 1–12, 33, 34, 53.) Although the notes were prepared by NP Mutuc, Respondent, as NP Mutuc's supervisor, was responsible for their accuracy and completeness. Cause therefore exists to discipline Respondent's certificate under section 2266 for failure to maintain accurate and adequate records.

6. The Medical Board of California Manual of Model Disciplinary Orders and Disciplinary Guidelines 2016 (Manual) groups the recommended discipline for violations of section 2266 with those of violations of 2234, subdivisions (b) and (c). The minimum discipline for violating these sections is revocation stayed for five years and the maximum is revocation. However, in an acknowledgment that lesser violations of a single statutory provision warrant less than a five-year-stayed probation, the

Guidelines note that a public reprimand is appropriate in certain cases of repeated negligent acts under section 2234, subdivision (c).

7. The purpose of licensing statutes and administrative proceedings enforcing licensing requirements is public protection and not to punish an errant practitioner. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784–786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) Respondent's violation of section 2266 was limited in both nature and scope and caused no harm. When considered with Respondent's evidence of mitigation and rehabilitation, i.e., his early acceptance of responsibility for his recordkeeping errors, his decision to terminate his employment of nurse practitioners, his 42-year history of licensure without prior discipline, and his laudable skills, compassion, and dedication to the profession and his patients, a public reprimand constitutes measured discipline appropriate for the violation established. (Factual Findings 87–93.) The public is best protected by serving notice of Respondent's violations without imposing overly harsh or punitive discipline. A medical recordkeeping course is unnecessary in light of GEMCH's extensive and independent review and ultimate approval of Respondent's charting. (Factual Finding 91.)

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ORDER

Physician's and Surgeon's Certificate No. A 32691 issued to Respondent Kamalakar Rambhatla, M.D. is hereby publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4).

DATE: 05/24/2021

Cindy F. Forman (May 24, 2021 16:13 PDT)

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings

Exhibit A

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KAMALAKAR RAMBHATLA, M.D. 3580 Santa Anita Avenue, Unit B El Monte, CA 91731 Physician's and Surgeon's Certificate No. A 32691, Respondent.	Case No. 800-2017-032890 **ACCUSATION**

PARTIES

1. Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about July 31, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number A 32691 to Kamalakar Rambhatla, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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7. Section 2266 of the Code, states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL ALLEGATIONS

Patient 1:

8. On November 25, 2016, Patient 1,[1] a 98-year-old female, was admitted to El Monte Community Hospital by nephrologist, Dr. M.R., with complaints of a cough, sore throat, chest wall pain, body aches and fever. Patient 1 had a normal chest x-ray upon admission. A follow up chest x-ray performed on November 29, 2016 revealed a small, 50% left-sided pleural effusion. Congestive heart failure was considered as a possible cause for the pleural effusion. Infectious disease, cardiology and pulmonology consults were obtained.

9. On November 30, 2016, Nurse Practitioner D.M.[2] performed a pulmonary consult for Patient 1's complaints of shortness of breath. Nurse Practitioner D.M. noted that Patient 1's chest x-ray revealed mild cardiomegaly with findings compatible with small bilateral pleural effusions, left greater than right, and adjacent atelectasis consolidation. She further noted that radiology recommended clinical correlation for underlying congestive heart failure versus infectious inflammatory processes. Nurse Practitioner D.M.'s assessment was acute bronchitis, fever, diabetes, hypertension and history of transient ischemic attack. She recommended that Patient 1 be continued on bronchodilators, antibiotics, with a repeat chest x-ray and monitoring for any respiratory distress and fever. Nurse Practitioner D.M. also noted that she discussed the plan of care with Respondent.

10. Chest x-rays performed on November 30, 2016 and December 1, 2016 revealed slightly increased congestive heart failure.

11. Patient 1 was next seen by Nurse Practitioner D.M. on December 1, 2016. Within the body of her progress note, Nurse Practitioner D.M. noted the radiological findings and impression

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[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1 and 2.

[2] Respondent, a pulmonologist, employed and supervised Nurse Practitioner D.M. as part of his pulmonology practice.

for the December 1, 2016 chest x-ray verbatim. Her assessment remained the same as set forth in her November 30th progress note. Her plan was to continue IV antibiotics, bronchodilators, supplemental oxygen as well as the patient's current plan of care. She further noted that she discussed the case with Respondent. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

12. On December 1, 2016, Patient 1 was also seen by cardiologist, Dr. S.K. He noted that the patient complained of a productive cough, but denied chest pain or shortness of breath. He formed the impression that the patient had bilateral pleural effusion. He noted that the radiology report indicated that the patient had congestive heart failure and pleural effusion; however, the patient did not have symptoms of orthopnea or shortness of breath. Dr. S.K. noted that the patient had mild to borderline aortic stenosis but that he doubted it was significant enough to cause acute congestive heart failure. A trial of diuretics was given with no improvement. Dr. S.K. recommended a CT scan of the chest and possible thoracentesis.[3]

13. Patient 1 was next seen by Nurse Practitioner D.M. on December 2, 2016. Within the body of her progress note, Nurse Practitioner D.M. again noted the radiological findings and impression for the December 1, 2016 chest x-ray verbatim. She did not note the results of the CT scan of the chest.[4] Her assessment and plan were identical to her previous progress note. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

14. Dr. S.K. saw the patient on December 2, 2016. He noted that the patient's chest x-ray taken that same day showed persistent bilateral pleural effusions and that the radiologist read it as congestive heart failure. He also noted that the December 1, 2016 CT scan of the chest revealed atelectasis, infiltrate and pleural effusion. Based on clinical presentation and the patient's normal

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[3] Thoracentesis is a procedure, performed by a pulmonologist, in which a needle is inserted into the pleural space between the lungs and the chest wall. The procedure is done to remove excess fluid, known as a pleural effusion, from the pleural space to help the patient breathe easier.

[4] The CT scan of the chest performed on December 1, 2016 revealed the presence of moderate bilateral pleural effusions and severe consolidation at both lung bases versus atelectasis. The radiologist's impression was severe bibasilar atelectasis versus bibasilar pneumonia and he recommended clinical correlation.

ejection fraction of the left ventricle, Dr. S.K.'s impression was that acute congestive heart failure was unlikely the cause for the pleural effusion and that the patient may need thoracentesis.

15. Patient 1 was seen by Nurse Practitioner D.M. on December 3, 2016. Within the body of her progress note, Nurse Practitioner D.M. repeated the radiological findings and impression for the December 1, 2016 chest x-ray verbatim. Her assessment and plan remained identical to her prior two progress notes. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

16. Patient 1 was seen by Dr. S.K. on December 3, 2016. He noted that the patient's chest x-ray showed persistent cardiomegaly and increasing left pleural effusion. His impression was progressive pleural effusion of an unknown cause and he again noted that the patient may need thoracentesis to assess her pleural effusion.

17. On December 4, 2016, Patient 1 was seen by Respondent. He noted that he spoke with Dr. S.K., who felt that the patient did not have significant congestive heart failure as a cause for her bilateral plural effusions and atelectasis. Within the body of his progress note, Respondent copied the radiological findings and impression for the December 1, 2016 chest x-ray verbatim. His assessment mirrored the assessment of his nurse practitioner: "acute bronchitis, fever, diabetes, hypertension and history of transient ischemic attack." His plan was to continue IV antibiotics, bronchodilators, supplemental oxygen, IV steroids and the use of BiPAP[5] on an as needed basis. Respondent also noted that if the patient's distress and cough persisted, thoracentesis would be considered. No reference was made to any discussions with the patient's family regarding the possibility of thoracentesis.

18. On December 5, 2016, the patient was seen by Nurse Practitioner D.M. Within the body of her progress note, Nurse Practitioner D.M. repeated the radiological findings and impression for the December 5, 2016 and December 1, 2016 chest x-rays verbatim. Her assessment and plan were identical to her previous progress notes with the addition of BiPAP on an as needed basis. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

[5] BiPAP is a type of positive pressure ventilator to treat respiratory distress.

19. On December 6, 2016, the patient was seen by Nurse Practitioner D.M. Within the body of her progress note, Nurse Practitioner D.M. copied the radiological findings and impression for the December 5, 2016 and December 1, 2016 chest x-rays verbatim. Her assessment and plan remained identical to her previous progress note. On December 7, 2016, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

20. Patient 1 was also seen by Dr. S.K. on December 6, 2016. He noted that the patient had a persistent pleural effusion of unknown cause but that he doubted that the cause was cardiac in origin. He recommended thoracentesis and noted the patient's family's request for conservative management.

21. On December 7, 2016, the patient was seen by Nurse Practitioner D.M. Within the body of her progress note, Nurse Practitioner D.M. again repeated the radiological findings and impression for the December 5, 2016 and December 1, 2016 chest x-rays verbatim. Her assessment and plan remained identical to her December 5th and 6th progress notes. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

22. On December 8, 2016, the patient was seen by Nurse Practitioner D.M. Within the body of her progress note, Nurse Practitioner D.M. again copied the radiological findings and impression for the December 5, 2016 and December 1, 2016 chest x-rays verbatim. Her assessment was unchanged. With respect to the patient's plan of care, she added skilled nursing home placement. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

23. Patient 1 was also seen by Dr. S.K. on December 8, 2016. He noted persistent pleural effusion of an undetermined nature. He again recommended thoracentesis but noted that the family requested conservative management. He also recommended a chest x-ray and laboratory testing the following morning.

24. On December 8, 2016, Dr. M.R. ordered the discharge of Patient 1 to a skilled nursing facility with her current medications "if OK with [Respondent.]" In response, Respondent ordered that it was okay to discharge the patient to a skilled nursing facility from a pulmonology standpoint.

25. On December 29, 2016, Patient 1 was admitted at El Monte Community Hospital by Dr. M.R. from Ramona Care Nursing Home with complaints of lethargy and mild hypoxia. A pulmonary consult with Respondent was requested to address her persistent pulmonary edema.

26. A chest x-ray performed on December 29, 2016 revealed a minimal right and moderate to large left pleural effusions with compressive atelectasis. By December 30, 2016, the patient's chest x-ray revealed complete opacification of the left hemithorax, increased since the prior examination, likely reflecting massive left pleural effusion with adjacent left lung atelectasis or collapse.

27. On December 30, 2016, Respondent performed a fiber-optic bronchoscopy and removed a mucous plug that was occluding the left mainstem bronchus. Following the procedure, the patient was observed in the intensive care unit for 30 minutes and thereafter returned to her room on the telemetry unit.

28. A chest x-ray performed at 4:00 a.m. on December 31, 2016 continued to show complete opacification of the left hemithorax. That same day, Nurse Practitioner D.M. noted that the patient had left lung opacification from pleural effusion and was status post bronchoscopy without significant improvement on chest x-ray. She noted "PATIENT WILL NEED THORACENTESIS AND THIS WILL BE DISCUSSED WITH THE PATIENT AND WILL BE SCHEDULED ACCORDINGLY." That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

29. The pleural effusion did not improve. On January 1, 2017 at 10:00 a.m., the patient went into respiratory failure and Code Blue was called. She expired at 10:31 a.m.

Patient 2:

30. Patient 2, a 44-year-old female, presented to the emergency department at Greater El Monte Community Hospital on July 7, 2017 with a one-day history of right upper quadrant pain with nausea. Respondent admitted her to the medical surgical unit of the hospital on July 8, 2017.

31. Patient 2 was seen by Nurse Practitioner D.M. on July 8, 2017. Nurse Practitioner D. M. prepared a history and physical report. She noted the results of the patient's laboratory testing performed on July 7, 2017. She assessed the patient with acute cholecystitis with cholelithiasis,

urinary tract infection and leukocytosis. The plan was for the patient to undergo a surgical consult. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s history and physical report.

32. On July 8, 2017, Patient 2 was seen in surgical consultation by Dr. S.M. who recommended a laparoscopic cholecystectomy secondary to acute cholecystitis.

33. Patient 2 was seen by Nurse Practitioner D.M. on July 9, 2017, at which time she noted that the patient was scheduled for a laporoscopic cholestectomy that same day. Nurse Practitioner D. M. noted the results of the patient's laboratory testing performed earlier that day. Respondent electronically co-signed Nurse Practitioner D.M.'s progress note that same day.

34. On July 9, 2017, the patient underwent a laparoscopic cholecystectomy by Dr. S.M. without complication.

35. Patient 2 was next seen by Nurse Practitioner D.M. on July 10, 2017 at which time she noted that the patient stated that she felt much better status post laparoscopic cholecystectomy. Nurse Practitioner D. M. noted the results of the patient's laboratory testing performed earlier that day. She recommended further laboratory studies the following morning as well as discharge planning. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s progress note.

36. Laboratory testing performed at 5:30 a.m. and reported at 9:40 a.m. on July 11, 2017 revealed an elevated creatinine level of 1.97, an increase from 0.87 on July 10, 2017.[6]

37. On July 11, 2017, Nurse Practitioner D.M. discharged Patient 2. In her discharge summary dictated at 10:15 a.m. and electronically signed at 10:16 a.m., Nurse Practitioner D.M. noted that the patient tolerated the laparoscopic cholecystectomy well and that she was cleared by the surgeon to be discharged. Nurse Practitioner D.M. did not note the results of the patient's laboratory testing performed earlier that morning, including the elevated creatinine level. That same day, Respondent electronically co-signed Nurse Practitioner D.M.'s discharge summary.

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[6] Normal creatinine levels ranged from 0.60 to 1.30. Elevated creatinine levels signify possible kidney malfunction or failure.

38. On July 14, 2017, Patient 2 presented to the emergency department with complaints of constipation and fever. Her creatinine level was significantly elevated at 6.59 and her blood urea nitrogen test (BUN)[7] was 34. She was noted to have urinary retention and renal failure. She was treated conservatively with Foley Catheter placement. She was also treated for a biliary fossa fluid collection below the liver. Ultimately, the patient's creatinine level gradually decreased to a normal level and she was discharged from the hospital on July 21, 2017.

STANDARD OF CARE

39. In managing pleural effusion, the standard of care for a pulmonologist requires that pleural effusion be drained and the pleural fluid analyzed to differentiate between transudate and exudate. The nature of the pleural fluid facilitates the diagnosis, management and the prognosis of the patient. The physician must assess the presence and progress of pleural effusions and implement a corresponding plan of action. If the procedure to drain the pleural effusion cannot be done for any reason, it should be discussed with the patient and patient's family. The reason for not proceeding with the drainage of the pleural effusion and alternative plans should also be clearly documented in the patient's record.

40. In supervising a nurse practitioner, the physician must communicate regularly with the nurse practitioner and oversee the quality of the nurse practitioner's care in order to recognize whether a patient's medical condition is deteriorating.

41. The standard of care requires that a physician review a patient's current vital signs and laboratory studies prior to discharge, as well as establish plans for patient follow up following discharge. Abnormal laboratory values must be addressed before the patient is discharged.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence in the Management of Patient 1's Progressive Pleural Effusion)

42. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in the management of Patient 1's progressive

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[7] BUN is a test that measures waste product in the blood and is used to assess kidney and liver function.

pleural effusion. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 29, 39 and 40, above, as though fully set forth herein. The circumstances are as follows:

43. Patient 1 presented with a normal chest x-ray at the time of her November 25, 2016 hospital admission. She had progressively increasing left sided pleural effusion at the time of her second admission on December 29, 2016, that ultimately caused a complete left-sided whiteout of the lung. Respondent failed to drain Patient 1's pleural effusion and order pleural fluid analysis in order to facilitate the diagnosis. Respondent failed to document any reason why the procedure could not be done and an alternative plan to draining the pleural effusion.

44. Respondent's acts and/or omissions as set forth in paragraphs 8 through 29, 39, 40, 42, and 43, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

45. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1 and 2. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 43, above, as though fully set forth herein. The circumstances are as follows:

46. Respondent was negligent in the care and treatment of Patient 1. The circumstances are as follows:

A. Patient 1 presented with a normal chest x-ray at the time of her November 25, 2016 hospital admission. She had progressively increasing left sided pleural effusion at the time of her second admission on December 29, 2016, that ultimately caused a complete left-sided whiteout of the lung. Respondent failed to drain Patient 1's pleural effusion and order pleural fluid analysis in order to facilitate the diagnosis. Respondent failed to document any reason why the procedure could not be done and an alternative plan to draining the pleural effusion.

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B. Respondent failed to recognize the deterioration of Patient 1's medical condition during the time periods he allowed Nurse Practitioner D.M. to provide care and treatment to Patient 1.

47. Respondent was negligent in the care and treatment of Patient 2 in that he failed to recognize and address Patient 2's abnormal laboratory value on the day of discharge from the hospital.

48. Respondent's acts and/or omissions as set forth in paragraphs 8 through 47, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

49. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to her care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 38, above, as though fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 32691, issued to Kamalakar Rambhatla, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 25 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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